

## 2900 FAIR HEARINGS AND APPEALS

Section 1902(a)(3) of the Social Security Act requires that States "provide for granting an opportunity for a fair hearing before the State agency to any individual whose claim for medical assistance under the plan is denied or is not acted upon with reasonable promptness." Regulations implementing this section of law are found at 42 CFR 431 Subpart E. In addition, certain court decisions further amplify and modify the law and regulations governing the provision of notices and hearings to Medicaid applicants and recipients. Where appropriate, those decisions are cited .

2900.1 Basic Responsibility (42 CFR 431.200 and 431.205).--Establish policies and procedures for assuring a system of fair hearings that meet all the requirements of the regulations and instructions.

Notify and make available to the applicant or recipient the hearing procedures required by regulations and these instructions, if any of the following events occur:

- o denial of eligibility,
- o the claim is not acted upon with reasonable promptness,
- o termination of eligibility or covered services,
- o suspension of eligibility or covered services, or
- o reduction of eligibility or covered service

2900.2 Publication And Distribution Of Hearing Procedures (42 CFR 431.206(a)). --Issue and publicize your hearing procedures. The publication and wide distribution of hearing procedures in the form of rules and regulations or a clearly stated pamphlet to appellants, recipients, and other interested groups and individuals helps to emphasize the purposes and importance of the procedure and to inform aggrieved individuals about the existence and use of this procedure. It not only contributes to the fairness and orderliness of the hearing, but also emphasizes the principles of equity and due process throughout the administration of medical assistance.

2900.3 Information And Referral For Legal Services (42 CFR 431.206(b)(3)).--Advise individuals appealing an agency decision of their right to be represented by a person or organization of their choice. You are not required to provide legal services. Legal aid societies, neighborhood legal services, lawyers in private practice, and perhaps other sources may be able and willing to provide representation for Medicaid applicants and recipients. In order to carry out the intent of the regulation, agencies should keep informed about such services and be prepared to advise appellants about them.

Because of the difficulties many recipients have in representing themselves in fair hearings, you have a special responsibility to assist persons in being represented by others and to help establish that such representation is not a violation of State law concerning non-legal representation, in those States where this has been an issue. Advise the appellant of any legal services which may be available to him (see §2909) and any provisions you have for payment of legal fees for representation at fair hearings.

2900.4 Informing Individuals of their Appeal Rights (42 CFR 431.206).--Notify in writing any applicant or recipient of the right to a hearing and the procedure for requesting a hearing at the time of application and at the time of any action by the agency. (See §2900.1 defining the action requiring Notice of Appeal Rights.)

You may give written notification on the application form or on other forms you routinely send to applicants and recipients. If you publish an agency pamphlet describing the provisions of your Medicaid program, include an explanation of the applicant's and recipient's appeal rights.

For applicants and recipients not familiar with English, include a translation into a language understood by the applicant or recipient of the appeal rights available to them. This should be done for all written communications with such applicants and recipients. You should also orally explain, in understandable language, the applicant's and recipient's appeal rights at the time of any face to face interview conducted by the agency.

## 2901. NOTICE AND OPPORTUNITY FOR A FAIR HEARING

2901.1 Advance Notice of Intent to Terminate, Reduce or Suspend Medicaid (42 CFR 431.211 and 431.213).--

### A. Advance Notice.

1. 10-Day Advance Notice.--Whenever you propose to terminate, reduce or suspend Medicaid covered services, mail advance notice of the pending action to the recipient at least 10 days prior to the time of the anticipated action, except as provided in subsections A2 and B. With respect to eligibility factors known in advance, such as attainment of age 18 or increased hours or wages of employment, (42 CFR 435.112), send the notice even earlier, thus allowing more time to resolve any issue or questions.

2. 30-Day Advance Notice.--Give an applicant or recipient 30 days advance notice whenever you propose to deny, terminate, reduce, or suspend eligibility or covered services because of data disclosed through a matching program covered under the Computer Matching and Privacy Protection Act of 1988 (P.L. 100-503).

This legislation amended the Privacy Act to establish procedures governing computer matches between Federal source agencies and State agencies. Adverse action resulting from a covered matching program cannot be taken until the adverse data have been independently verified. This verification can be satisfied by verification from the source agency or from the applicant or recipient. Independent verification may be done during the advance notice period, except for data covered by 42 CFR 435.952 and 435.955 which must be verified prior to notification. Where the information involves income or resources, the law requires that at least the following must be verified:

- o The applicant's/recipient's total income and/or total value of owned assets;
- o The applicant/recipient has or did have access to the assets or income;
- o Confirmation of the period of time when the applicant/recipient owned the asset or earned the income.

Before you may deny, suspend, terminate, or reduce benefits to an applicant/recipient as a result of information produced from a matching program, the following conditions must be met:

- o The applicant/recipient must receive a written notice identifying the adverse data you propose using and the action you propose to take because of this data;
- o The applicant/recipient must be given 30 days advance notice of the opportunity to contest the data and findings before you may take adverse action; and
- o You must allow the 30-day period to expire before taking adverse action against the applicant or recipient.

If the individual contests SDX data and alleges receiving an ongoing SSI check, ask the individual to bring in the most recent SSI notice or a copy of the next check as verification. Continue Medicaid eligibility based on receipt of SSI if the recipient does so. Contact SSA for verification of SDX data only if the recipient contests the data but is completely unable to provide evidence to refute the SDX and you are otherwise unable to verify the SDX data.

B. Less Than 10 days Advance Notice.--In the following circumstances advance notice may be reduced or is not necessary. Advance notice may be reduced to 5 days in cases where you have facts indicating action should be taken because of probable fraud by the recipient.

You do not have to send advance notice if:

- o You have factual information that the recipient has died;
- o The recipient has stated in writing that he no longer wishes Medicaid or the information he has given requires termination of Medicaid and the recipient knows that is the result of giving the information;
- o The recipient has been admitted to an institution where he is ineligible under the State Plan for services. For example, in a State which does not provide Medicaid to inpatients over 65 years old, in a mental institution, a recipient admitted to such an institution is not eligible for such services;
- o The recipient moves to another State (or another county in county administered programs) and has been determined eligible for Medicaid in the new jurisdiction; and
- o The recipient's whereabouts are unknown. You may determine that the recipient's whereabouts are unknown if mail sent to the recipient is returned as undeliverable.

2901.2 Notice When a Change in Level of Care Occurs.--In the following circumstances send a notice reflecting a change in the level of care an institutionalized recipient receives:

- o The recipient continues to be a patient of the institution,
- o The change in level of care was ordered by the recipient's physician, and
- o The change in level of care is to a lower level of care covered by the program.

If all of the preceeding conditions are met, notice may be sent on the date of action.

If all of the conditions above are not met, send advance notice as required by §2901.1.

2901.3 Opportunity for a Fair Hearing --All applicants and recipients sent a notice as required by §2901.1 may request a Fair Hearing. Except as provided elsewhere in this section grant a timely request for a hearing and render a decision in the name of the agency.

In providing an opportunity for a Fair Hearing, regulations at §431.221 require that you must establish a reasonable time period not to exceed 90 days from the date notice of action is mailed to request a hearing.

A period of not less than 20 days after mailing a notice of action ensures that applicants and recipients have sufficient time in which to request a hearing. HCFA considers a period of less than 20 days for appeal as unreasonable, because delays in receipt of the notice provide too little time in which to make a timely appeal.

Make every effort to assist applicants and recipients to exercise their appeal rights. For example, you may need to help applicants or recipients who do not have anyone else to assist them in preparing for a hearing. If you provide an informal conference, make it clear to the applicant or recipient that such a conference is not part of the hearing process.

You do not have to grant a hearing if the sole issue being appealed is a State or Federal law or policy, including a change in law or policy adversely affecting some or all applicants or recipients. See §2902.3 for a discussion of the distinction between issues of fact and issues of policy.

## 2902. HEARINGS

**2902.1 Request for a Hearing**--A request for a hearing must be in writing and signed by the applicant or recipient, or the authorized representative of the applicant/recipient.

In the case of authorized representatives, you must have evidence that the individual claiming to represent the applicant/recipient has been authorized to do so.

Oral inquiries about the opportunity to appeal should be treated as requests for appeal for purposes of establishing the earliest possible date for an appeal.

If you provide a conference to applicants or recipients who have been sent notices of action the applicant may request a hearing without first having a conference and such conference may not substitute for the hearing.

Promptly acknowledge every hearing request received.

## 2902.2 Continuation and Reinstatement of Services Pending a Hearing Decision--

A. **Required Continuation or Reinstatement**--Continue to provide or reinstate Medicaid services until a hearing decision has been rendered in the following circumstances.

1. **Continue Services**--If you mail the 10 day or 5 day notice as required and the recipient requests a hearing before the date of action, continue Medicaid services.

2. Reinstate services if:

- o You take action without the advance notice required;
  - o The recipient's whereabouts are unknown (agency mail is returned as undeliverable) but during the time the recipient is eligible for services the recipient's whereabouts become known, or
  - o The recipient requests a hearing within 10 days of mailing the notice of action;
- and
- o You determine that the action results from other than the application of Federal or State law or policy.

B. Optional Reinstatement.--You may reinstate services if the recipient requests a hearing not more than 10 days after the date of action.

C. When Maintained for Reinstated Services May be Stopped.--You must continue to provide services maintained or reinstated after an appeal until a hearing decision is rendered unless the hearing officer, at the hearing, determines that the sole issue is one of Federal or State law or policy. When the hearing officer determines the appeal is one of law or policy, you may discontinue services but only after promptly informing the recipient in writing that services will be discontinued pending the hearing decision.

2902.3 Dismissal of A Hearing Request.--

A. Dismissal.--You may dismiss a request for a hearing when:

- o The claimant or his representative requests in writing that the request for hearing be withdrawn; or
- o The claimant abandons his right to a hearing as described in subsection B.

B. Abandonment.--The hearing request may be considered abandoned when neither the claimant nor his representative appears at scheduled hearing, and if within a reasonable time (of not less than 10 days) after the mailing of an inquiry as to whether he wishes any further action on his request for a hearing no reply is received.

2902.4 Nature Of The Issue.--Determine whether the appeal involves issues of law or policy, or issues of fact or judgement. The decision will affect whether a hearing is granted and whether Medicaid will be continued pending the hearing decision. The distinction between issues of fact or judgment and issues of State law or agency policy will not usually be difficult to make. Issues of fact or judgement include issues of the application of State law or policy to the facts of the individual situation.

A. Issues of Law or Policy.--An example of an issue involving application of agency policy to the individual situation may arise from the use of spenddown. If there is a question whether the formula for computing spenddown was correctly applied in an individual case, it is an issue of fact or judgment and assistance must be continued. If the individual challenges the use of spenddown, he is questioning the policy itself, and assistance would not need to be continued during the fair hearing process.

An example of an issue of agency policy is the alleged inadequacy of the State program, e.g., the failure to include eyeglasses or dental care in the services for which recipients are eligible. Such inadequacies are grounds for requesting a fair hearing. However, the agency is not in a position to rule in favor of the appellant without a change in agency policy or, in some instances, in State law. You are not required to continue assistance during appeals of this type.

B. Issues of Fact or Judgment.--Examples of situations where issues of fact or judgment may arise are:

- o An agency decision of permanent and total disability. There may be a difference of opinion as to whether the condition is such as to justify a finding of disability (team's judgment) as defined in 42 CFR 435.541 or there may be a question as to the "facts" in the medical report; or

- o Whether a father works a sufficient number of hours to exclude the family from being eligible on the basis of excess hours or earnings (42 CFR 435.112).

2902.5 Group Hearings (42 CFR 431.222).--Joint or group hearings when more than one individual protests identical issues of agency policy (if the State grants a hearing in such circumstances) may be economical for the agency and beneficial to the aggrieved individuals. A joint or group hearing makes available to each appellant the opportunity for presenting his case with others when all have the same complaint. For example, a number of recipients may ask for a hearing on the State's decision to delete from coverage a certain drug because it has not been proven effective.

If there is disagreement between agency and appellant as to whether the appeal concerns policy and identical facts or the facts of his personal situation, and thus whether it may be included in a group hearing, the hearing officer makes the decision. When an appellant's request for a fair hearing involves issues in addition to the one serving as a basis for the group hearing, you should sever his appeal from the group and handle separately. Likewise, a claimant scheduled for a group hearing may withdraw and request an individual hearing.

In a group hearing, accord individual appellants the right to make individual presentations and to be represented by their own representatives. Set up procedures to assure an orderly process in a group hearing.

2902.6 Convenience of the Claimant Considered (42 CFR 431.240(a)(1)).-- Consider the convenience of the claimant in setting the date, place, and time for the hearing. Give written notice for the claimant with adequate preliminary information about the hearing procedure. The agency has not discharged its responsibility unless it has done what it can to enable a claimant who has requested a hearing to attend the hearing in person and to be represented by a person of his own choosing. There may be instances in which the claimant is housebound, hospitalized or in a nursing home, or lives far from the office in which hearings are usually held. In these and other hardship instances, make special plans, as necessary, for the convenience of the claimant. For instance, the hearing may be held in the claimant's home. You may also conduct the hearing by telephone when the claimant is unable to attend in person. Telephone hearings must follow all of the due process required of in person hearings.

2902.7 Impartiality Of Official Conducting The Hearing (42 CFR 431.240(a)(3)).--The State official or panel conducting the hearing shall not have been connected in any way with the previous actions or decisions on which the appeal is made. For example, a field supervisor who has advised the local agency in the handling of a case would be disqualified from acting as the hearing officer, however a different field supervisor could serve.

2902.8 Claimant's Right To A Different Medical Assessment (42 CFR 431.240(b)).--An appeal on medical issues may involve a challenge to the Medical Review Team's decision regarding disability; or there may be disagreement about the content of reports concerning the appellant's physical or mental condition or the individual's need for medical care requiring prior authorization. When the assessment by a medical authority, other than the one involved in the decision under question, is requested by the claimant and considered necessary by the hearing officer, obtain it at agency expense. The medical source should be one satisfactory to the claimant. The assessment by such medical authority shall be given in writing or by personal testimony as an expert witness and shall be incorporated into the record.

2902.9 Rights Of Claimants During Hearings (42 CFR 431.242).--Provide the appellant or his representative an opportunity to examine all materials to be used at the hearing. Non-record or confidential information which the claimant or his representative does not have the opportunity to see is not made a part of the hearing record or used in a decision on an appeal. If the hearing officer reviews the case record, or other material, including the hearing summary proposal by agency staff, such material must also be made available to the appellant or his representative. The hearing officer must enable the appellant and his witnesses to give all evidence on points at issue and the appellant and his representative to advance arguments without undue interference. Give the appellant the opportunity to confront and cross-examine witnesses at the hearing and to present evidence in rebuttal. Do not use application of the rules for the conduct of the hearing to suppress the appellant's claim. Allow the claimant to present his case in the way he desires. For example, some claimants wish to tell their own story or have a relative or friend present the evidence for them and others may be represented by legal counsel or other spokesman. Make provisions to secure an interpreter when an appellant can't speak English.

2902.10 Prompt, Definitive And Final Action (42 CFR 431.244(f)).--The requirement for prompt, definitive, and final administrative action means that all requests for a hearing are to receive prompt attention and will be carried through all steps necessary to completion. The requirement is not met if the State dismisses such a request for any reason other than withdrawal or abandonment of the request by the claimant or as permitted elsewhere in these instructions. Adhere to the time limit of 90 days between the date of the request for the hearing and the date of the final administrative action except where the agency grants a delay at the appellant's request, or when required medical evidence necessary for the hearing can not be obtained within 90 days. In such case the hearing officer may, at his discretion, grant a delay up to 30 days.



## 2903. HEARING DECISION

2903.1 Basis for Hearing Officer Recommendation, Decision, And Opportunity to Examine Official Record (42 CFR 431.244).--The hearing officer's recommendation or decision shall be based only on the evidence and testimony introduced at the hearing. The record of the proceedings, which consists of the transcript or recording of the hearing testimony, any exhibits, papers or requests filed in the appeal, including the documents and reasons upon which the determination being appealed is based, and the hearing officer's written recommendation or decision shall be available to the claimant or his representative at a convenient time and at a place accessible to him or his representative, to examine upon request. If any additional material is made part of the hearing record it too shall be made available.

2903.2 Hearing Decision And Notification to Claimant (42 CFR 431.232, 233, 244(b)and(d) and 431.245).--

A. General.--A conclusive decision in the name of the State agency shall be made by the hearing authority. That authority may be the highest executive officer of the State agency, a panel of agency officials, or an official appointed for the purpose. No person who has previously participated at any level in the determination upon which the final decision is based may participate in the decision. For example, a person who participated in the original determination being appealed may not participate in the appeal; nor may a person who participated in a local hearing participate in the agency hearing.

The officially designated hearing authority may adopt the recommendations of the hearing officer, or reject them and reach a different conclusion on the basis of the evidence, or refer the matter back to the hearing officer for a resumption of the hearing if the materials submitted are insufficient to serve as basis for a decision except where the appeal involves the issue of disability and SSA has issued a disability determination which is binding on the program. Remanding the case to the local unit for further consideration is not a substitute for "definitive and final administrative action."

B. Hearing Records.--All hearing recommendations or decisions must be based exclusively on evidence introduced at the hearing. The record must consist only of:

- o The transcript or recording of testimony and exhibits, or an official report containing the substance of what happened at the hearing; and
- o All papers and requests filed during the appeal; and
- o The recommendation or decision of the hearing officer.

C. Local Evidentiary Hearing--Where you provide a local evidentiary hearing, include the following information in the decision and take the action described.

- o Inform the applicant or recipient of the decision;
- o Inform the applicant or recipient that he has the right to appeal the decision to the State agency within 15 days of mailing the decision;
- o Inform the applicant or recipient of his right to request that the appeal be a de novo hearing, subject to the limit set forth in paragraph A;

- o The decision shall state the specific reasons for the decision, identify the supporting data, and be issued promptly to the claimant in writing; and

5. The State shall discontinue services after the decision if it is adverse to the recipient.

**D. State Agency Hearing.**--

- o Unless the claimant specifically requests a de novo hearing, the hearing may consist of a review of the local evidentiary hearing, by the agency hearing officer to determine whether the local hearing decision was supported by substantial evidence.

- o A person who participated in the local decision may not participate in the State agency hearing.

- o In the final decision give the specific reasons for the decision, identify the supporting data, and issue it promptly to the claimant in writing.

- o In the notice of decision advise the claimant of the right of judicial review if it is prescribed by State statute specifically authorizing review of agency decisions on the basis of the record of administrative proceedings, or if there is other provision for judicial review under State law.

**2903.3 State Agency Responsibility In Carrying Out The Hearing Decision ( 42 CFR 431.244(f)).**--

A. **General.**--The hearing authority's decision is binding upon the State and Local agencies. You are responsible for assuring that the decision is carried out promptly. Various methods, such as report by the local agency on action taken, or follow-up by State office staff, may be used.

B. **Final Administrative Action.**--Section 431.244(f) requires that you take final administrative action within 90 days of the request for hearing. In implementing this regulation it is reasonable to allow additional time to meet this standard when a delay beyond 90 days is due to claimant requests or untimely receipt by the hearing authority of documentation needed to render a decision which had been requested timely. Any delay can not exceed 30 days.

C. **Corrective Action.**--If the hearing decision is favorable to the claimant, or if the agency decides in favor of the claimant prior to a hearing, promptly take action to reinstate Medicaid eligibility and process any unpaid providers claims within the standard set forth in B.

**2903.4 Accessibility Of Hearing Decisions To Local Agencies And The Public (42 CFR 431.244(g)).**--Select a method for informing all local public welfare agencies of all hearing decisions and of making such decisions available to all interested members of the general public. The method may provide for a summary presentation. Where several decisions centered around the same question, it is permissible to treat one decision with some detail, and then indicate in a much more abbreviated fashion for each of the subsequent decision that it raises the same question and follows the precedent of the initial case. Such information must be preserved in a manner consistent with requirements for safeguarding information concerning applicants and recipients in 42 CFR 431 Subpart F.

2903.5 Responsibility for Hearings Under Medicaid (431.243).--If the hearing involves an issue of eligibility and the Medicaid agency is not responsible for eligibility determinations, the State agency that is responsible for determining eligibility must participate in the hearing.

The two agencies should work out the precise arrangement between them for conducting such hearings. In doing so, the Medicaid agency may use the hearing process employed by the State agency which made the eligibility determination; the hearing officer in such cases will make a recommendation to the Medicaid agency. That agency is responsible for presenting to the hearing officer the agency's justification for the decision it made, and the evidence upon which it is based.

The decision rendered as a result of a hearing described in this situation will be made in the name of the Medicaid agency. The Medicaid agency is responsible for the implementation of the decision. However, none of the procedures allowed by this section may be used to deny a claimant any of the due process rights contained elsewhere in these instructions.

#### 2904. REOPENING AND RECOVERY

2904.1 Reopening Final Determinations Of Eligibility.--Reopening a final determination permits the correction of errors in that determination. It is particularly suited to changing a determination which was reasonable when rendered but is now unreasonable because new evidence concerning the determination has been submitted which may alter that determination. However, unrestricted reopening would seriously impair due process, administrative efficiency and that certainty in determinations which applicants and recipients have the right to expect. Consequently, reopening should be permitted only when there is good cause to question the accuracy of a determination. The following discussion sets out procedures which you may wish to follow in designing rules to govern reopening of fair hearing determinations.

A. Who May Reopen An Initial, Revised Determination Or Hearing Decision.--You may reopen and revise any determination you have issued within the time limits and for the reasons described below.

##### B. Action Permitting Reopening--

- o Written request by the applicant, recipient or his representative, within the time limit, alleging good cause for reopening a previously final determination, or

- o You may, on your own notion, reopen a determination when you have information documenting that the previous determination is incorrect or there is other good cause.

##### C. Definition of Good Cause for Reopening.--

- 1. New and Material Evidence.--Any evidence which was not considered when the previous determination was made and which shows facts that may result in a conclusion different from the previous decision, even though the previous determination was entirely reasonable when it was made.

It is also possible that the evidence may justify or require that further development be undertaken before making a revised determination.

2. Clerical Error.--Any mechanical, computer or human mistakes in mathematical computations. For example, errors in computing resources, income, or spenddown requirements for Medicaid eligibility.

3. Error on the Face of the Evidence.--Any error in making a Medicaid determination which causes that determination to be incorrect at the time it is made. For example, evidence is on file to show that the applicant's resources meet the State's standard for eligibility yet the application is denied.

D. Time Limit for Reopening.--You may reopen a previously final Medicaid determination within 1 year of that determination when the conditions in paragraph C are met, except when the determination involves fraud. In such cases there is no time limit.

E. Reopening at any time.--You may reopen a previously final Medicaid determination at any time if you have evidence that the determination was obtained through fraud.

2904.2 Recovery.--

A. You may recover from the recipient money you paid for services provided the recipient if:

- o The services were provided as a result of §2902.2A1, and
- o The recipient's appeal is unsuccessful.

B. Inform the recipient of this provision at the time a hearing is requested if you employ recovery.

**2905. OUTSTATIONING OF ELIGIBILITY WORKERS--GENERAL**

Section 1902(a)(55) of the Act provides for the receipt of, and initial processing of, applications for Medicaid from mandatory and optional poverty level pregnant women and children under age 19, at locations other than welfare offices. These covered groups are defined in §§1902(a)(10)(A)(i)(IV), (a)(10)(A)(i)(VI), (a)(10)(A)(i)(VII), and (a)(10)(A)(ii)(IX) of the Act. While you may make eligibility determinations at outstation locations, subject to §§2909 and 2910, it is not required.

**2906. OUTSTATION LOCATIONS**

At a minimum, at least each disproportionate share hospital and each Federally Qualified Health Center (FQHC) that participates in the State's Medicaid program must have a person qualified, as described in §2909, to take applications and assist applicants with the application process. In meeting the requirements of this section:

- o Include as outstation locations, Indian Health Service clinics operated by a tribe or tribal organization which are included in the definition of rural health clinics; and
- o Enter, at your option, into reciprocal agreements with adjoining States to assure that the target population, living in border areas of your State, has the opportunity to apply for Medicaid at the health care locations they normally frequent when those facilities are in another State.
- o When an FQHC or disproportionate share hospital has more than one site, assure that applications for Medicaid can be taken at all sites. At locations where children and pregnant women seldom receive services, see §2908 for options in receiving applications and initial processing of applications. You may also provide eligibility workers at locations other than FQHCs and disproportionate share hospitals to the extent deemed appropriate.

**2907. STAFFING AT OUTSTATION LOCATIONS**

When outstationing eligibility workers, you must assure that staff is available at the outstation locations during the hours your offices are normally open to accept applications and assist applicants with the application process except as provided in §2908. For these purposes, outstationed eligibility workers do not have to be employees of the SA, but must be trained to assist applicants in filing applications and to answer accurately questions applicants may have or to refer such questions to the SA for an answer. At a minimum, applications meeting the requirements of §2910 must be available at all FQHCs and disproportionate share hospitals and someone must be available to assist applicants in completing the forms. The State plan must include a description about how this provision will be met.

**2908. GUIDELINES FOR OUTSTATIONING AND PROVIDING APPLICATION ASSISTANCE AT LOW USE LOCATIONS**

Where you encounter outstation locations at which children and pregnant women are seldom provided services, you may use any of the following practices to assure that such individuals are provided an opportunity to apply for Medicaid at the outstation location. You may use volunteers, provider employees, telephone assistance, or your own staff. When using State staff you may assign an agency employee to assist applicants at several outstation locations on a rotating basis. When any of these eligibility workers are not available, a

notice is prominently displayed at the location advising potential applicants about when such eligibility workers are available. This notice provides a telephone number which the applicant can call for assistance with initial processing of an application. Have copies of the Medicaid application available at all locations where children and women receive services.

#### 2909. LIMITATIONS ON OUTSTATIONED ELIGIBILITY WORKERS

When taking applications at outstation locations, the following conditions and restrictions apply:

A. State Employees Who Are Outstationed.--These employees may perform any tasks in connection with the receipt of, and processing of, an application for Medicaid at an outstation location which the employee could perform at the offices of the State agency, including the eligibility determination. In those States which are county administered any reference to State employees is considered a reference to county employees.

B. Provider or Contractor Employees.--These individuals when employed at outstation locations to receive and perform initial processing of applications, including any required interview, may take all actions except evaluating the information provided on the application and supporting documentation, and/or making an eligibility determination. When contractor or provider employees, including provider contractors, perform outstation activities you must assure, whether by contract or other means, that they adhere to State and Federal confidentiality provisions concerning applicant and recipient information and adhere to all conflict of interest prohibitions. (See §2912.)

C. Volunteers.--Volunteers may be employed to provide the same assistance as provider or contractor employees at outstation locations. The same provisions apply to volunteers as apply to provider employees concerning adherence to State and Federal confidentiality provisions and conflict of interest prohibitions. (See §2912.)

#### 2910. APPLICATION PROCESS

A. Initial Processing.--Initial processing means taking applications, assisting applicants in completing the application, providing information and referral, obtaining required documentation needed to complete processing of the application, assuring completeness of the information contained on the application, and conducting any interviews. Initial processing does not mean evaluating the information contained on the application and the supporting documentation nor making a determination of eligibility or ineligibility.

The date the application is completed and signed at the outstation is the application date for purposes of timely processing under 42 CFR 435.911 and determination of retroactive eligibility under 42 CFR 435.914. In States which require a face-to-face interview before determining eligibility, the interview may be conducted at the outstation location.

B. Further Processing.--Further processing means examining and verifying information provided on the application, and making the eligibility determination. It also means conducting follow up interviews when additional information is required but was not obtained during initial processing.

C. Outstation Activities.--Perform initial processing and, at your option, further processing of applications at outstation locations. You may complete processing of eligibility, including determining eligibility, at the outstation location only if the outstation location is staffed with State agency personnel with the authority to make determinations of eligibility. As provided by 42 CFR 431.10(c) and (e), only Medicaid agency officials or the other agencies specified in this section may make determinations of eligibility for Medicaid.

#### 2911. APPLICATIONS

The application form(s), including computerized applications, used at outstation locations may be an application designed for the target population, an application already used by Medicaid for applicants seeking Medicaid only, or a combined programs application where only that information appropriate for the Medicaid program by the target population is obtained.

The sole application form used at outstation locations may not be the AFDC application form as provided by §1902(a)(55) of the Act. Where a multi-program form is used, the person assisting the applicant and the form itself must make clear that only the information pertinent to Medicaid eligibility for the groups described in §2905 needs to be completed. The application used includes all of the questions which the applicant must answer in order to become eligible.

#### 2912. COMPLIANCE WITH FEDERAL REGULATIONS

The SA must assure that all outstation activities are subject to compliance with the instructions in §2910 and the following regulations, no matter who is authorized to perform outstation activities:

- o 42 CFR 431.10 requires that the single State agency must not delegate to others the authority to make eligibility determinations except as permitted by 42 CFR 431.10;
- o 42 CFR 431.200-250 requires that all applicants who are denied eligibility or whose application is not acted upon with reasonable promptness are provided notice and due process;
- o 42 CFR 431.300-307 requires that the confidentiality of applicant and recipient information be protected and that all persons with access to such information are subject to standards of confidentiality applicable to SA officials; and
- o 42 CFR 447.10 prohibits certain actions by providers and their agents, including contractors. Such activities are also subject to all other State and Federal laws concerning conflict of interest.

#### 2913. FFP FOR OUTSTATIONING

FFP is available as an administrative match for costs incurred by the State to implement and provide outstationing of eligibility workers. Such workers may be State employees, provider employees, volunteers, or provider contractors. HCFA pays for necessary administrative costs such as salary, fringe benefits, travel, training, equipment, and space directly attributable to the outstationing of eligibility workers.

## 2975. CONTINGENCY FEE REIMBURSEMENT FOR THIRD PARTY LIABILITY IDENTIFICATION OR COLLECTION

Contingency fee contracts or performance contracts fall into the category of fixed price contracts which allow for an adjustable fee based upon the occurrence of events or contingencies specified in the contract. The general use of contingency fees is permitted as a reimbursement basis in contracting. In this context, the percentage of reimbursement is fixed in the contract (e.g., 5 percent of all recoveries) but the actual amount of reimbursement depends upon the contractor's performance, i.e., the amount of third party resources established or payments recovered.

Use the following guidelines for contingency fee reimbursement of professional services by attorneys or private contractors to identify and/or collect Medicaid third party liability (TPL) payments, and:

- o To develop performance standards for contingency fee contracts;
- o To determine the level of appropriate reimbursement; and,
- o To report recoveries and fees for receipt of Federal financial participation (FFP).

General guidance for contracts between States and fiscal agents or other contractors is found at §2080. If a State contracts with its fiscal agent for the performance of any of the required TPL activities, guidelines at §2080.16 set forth some acceptable variations in performance standards and methods of payment. While the guidelines below deal only with contingency fee contracts for TPL identification or recovery, all contracts must meet the "proper and efficient" requirements discussed below.

2975.1 Authority.--Section 1902(a)(25) of the Social Security Act (the Act) requires that States take all reasonable measures to ascertain the legal liability of third parties to pay for medical services furnished to a Medicaid recipient under the State plan.

Section 1902(a)(4) requires that the State plan provide for methods of administration which the Secretary finds necessary for the proper and efficient operation of the plan.

Section 1903(a)(7) and 42 CFR 433.15(b)(7) provide for payment of 50 percent of the amounts the State has expended, as found necessary by the Secretary, for the proper and efficient administration of the State plan.

Regulation 42 CFR 433.139 requires States to use the cost avoidance method of paying claims involving TPL (rather than benefit recovery) if probable liability is established at the time the claim is filed (unless HCFA has approved a waiver under that part). If the probable existence of TPL cannot be established at the time the claim is filed, payment must be made and recovery pursued if TPL is later established.



2975.2 Contracting Principles--Contingency fee contracts are subject to the requirements of 42 CFR Part 434, Contracts Administration of Grants, as well as 45 CFR Part 74. Procurement standards are set forth in 45 CFR Part 74, Appendix G. The "cost plus a percentage of cost" method of payment is not allowable. Sole source, a form of noncompetitive negotiated procurement, may be conducted only under the limited conditions specified in this Appendix.

Competition is open to all potential contractors, including fiscal agents or their subsidiaries. However, be sure to protect against conflicts of interest, whereby a fiscal agent fails to identify and/or edit out a claim with TPL and then is given an additional amount under the contingency fee contract to collect for its own mistake. In your request for proposal, require potential bidders to submit proof that no conflict of interest exists. If bidders cannot do so, disqualify them.

In regard to safeguarding information on applicants and recipients, the contractor is held to the identical standards of confidentiality as those imposed on the State by §1902(a)(7) of the Act. Regulations at 42 CFR Part 431, Subpart F, specify the State plan requirements, the types of information to be safeguarded, the conditions for release of safeguarded information, and restrictions on the distribution of other information. Contracts must reflect that contractors and subcontractors understand and are bound by the safeguarding regulations.

Consult with the HCFA RO before entering into a contingency fee arrangement. The RO will review the potential contract using the guidelines outlined in §2975.3 to offer its opinion on the appropriateness of such an arrangement and reduce the possibility of a subsequent denial or deferral of FFP. If you enter into a contingency fee contract without the HCFA RO's prior review, HCFA can request the final contract under the authority of §1903(a)(7) of the Act and 42 CFR 433.15(b)(7) to establish whether the arrangement qualifies for FFP.

2975.3 Types of Contracts and Availability of Federal Financial Participation--States are required to take all reasonable measures to ascertain the legal liability of third parties to pay for care and services available under their State plans. Thus, a contingency fee contract may cover any reasonable measures to identify third party sources, to establish TPL, to collect from third parties, or for any combination of these activities.

A. Identification of TPL--The purpose is to establish the existence of any liable third party resource. The contractor does not actually collect funds but may bill the third party source specifying remittance to the State.

B. Collection of TPL--The purpose is to collect payment from liable third parties that have been previously identified.

C. Identification and Collection of TPL.--The contract provides for a broad range of varied responsibilities and procedures for the identification of and/or collection from liable third party resources.

Contractor contingency fee reimbursement based on TPL savings is generally appropriate regardless of the source or type of TPL. However, there may be circumstances in which a contingency fee arrangement does not qualify for FFP. Section 1903(a)(7) of the Act provides that FFP in State expenditures is only available when necessary for the proper and efficient operation of the State plan. However, a State may choose to enter into a contingency fee contract, paying the fee from State only funds. Whether the contract meets the "proper and efficient" condition and is eligible for FFP is determined by consideration of the following:

- o Current size and effectiveness of the State's TPL unit; appropriateness of contracting out a collection activity which might easily be handled inhouse;
- o Fiscal agent's existing TPL responsibilities under its claims processing contract;
- o Time, effort and capital outlay required of contractor to perform TPL responsibilities;
- o Automation capabilities for data matching and inhouse identification;
- o Extent of State's system for cost avoiding claims under 42 CFR 433.139 and the routine nature of collection for waived services;
- o Effectiveness of current methods for post payment recovery that would be more efficiently administered under a cost avoidance system;
- o Comparable cost for the State to perform the same function inhouse as those functions that will be performed by the contractor; and
- o Excessive cost of the contract in relation to the services performed. (Very little effort may be required to establish liability on the part of a total Federal entity. It may only require the proper coordination of paper work.)

2975.4 Contingency Fees and Cost Avoidance.--Contingency fee contracting may be utilized in the identification of TPL for the purpose of cost avoidance or collection (or both) with the following qualifications:

A. Nonreimbursable Recoveries.--Only savings attributable to the contractor's activity are reimbursable on a contingency basis. FFP is not available for recoveries (collections or cost avoidance) which require no action by the contractor. The following, while not all inclusive, are examples of nonreimbursable activities:

- o Third party payments shown on a claim as collected by the provider's action;
- o Overpayments refunded voluntarily by a provider;
- o Cost avoidance from third party resources previously identified in your files; and
- o Claims cost avoided subsequent to the contractor's initial identification of a third party source.

B. Audit Trails.--There must be audit trails showing the claims that were recovered or cost avoided. Also, there must be a system to insure that claims counted as cost avoided and returned to a provider are not paid by Medicaid on a subsequent submission. The system must prevent duplicate counting of cost avoided claims.

C. Reimbursement.--Calculate reimbursement for cost avoided claims on the amount of the Medicaid payment avoided, not on the charge submitted.

2975.5 Level of Reimbursement.--It is not HCFA's role to establish maximum percentages or fixed levels of reimbursement for contingency fee contracts either nationally or in individual States. However, HCFA does have the responsibility to insure that the reimbursement is reasonable for the services provided and the expenditure is appropriate for "proper and efficient administration of the State Plan." It is particularly important that identifying and/or collecting TPL from any Federal source be cost effective to be considered proper and appropriate.

Proposed contracts should be reviewed by the appropriate State component as well as HCFA's RO, Division of Financial Operations or Medicaid Operations. In evaluating the proposed contingency fee, while this list is not all inclusive, consider the following factors:

- o Need for design and development of a new or improved system by the contractor;
- o Degree of difficulty in identifying and/or verifying third party resources;
- o Extent of professional relations contractor will undertake with providers and insurance carriers;
- o TPL training for providers by the contractor;
- o Contractor maintenance of the third party resource file;
- o Contractor operation of an insurance carrier billing system;

- o Comparable cost for the State to perform the functions inhouse;
- o Time, effort and capital outlay required of the contractor;
- o Contractor operation of a cost avoidance system; and
- o Contractor operation of an accounts receivable system.

A separate fee must be established for each type of third party identification and/or collection activity. A flat fee that combines various types of third party identification/collection activities (including Federal entities) is not considered proper and efficient unless the fee reflects the approximate percentages of time to be spent in the various activities and the level of effort required in each.

2975.6 Financial Reporting.--Administrative monies must be separated from program benefit dollars. Contract fees for identification and/or collection from liable third parties are administrative expenses. Consequently, for the purposes of financial reporting, the net amount recovered by you with respect to medical assistance is the total amount of the overpayment prior to the deduction of any collection expenses. Report this figure at the applicable rate on the HCFA Form 64.9a. Any proper administrative expenses (attorney/contractor collection fees) incurred by you in identifying or collecting from third parties are eligible for reimbursement at a 50 percent rate and reported as such on HCFA Form 64.10.

It is customary for contractors/attorneys to take their fee "off the top" and to return the TPL recovery less their fee. Where this procedure is permitted under State law, it simplifies and facilitates the cash flow for the administrative cost of the contract. Report as administrative costs any funds properly retained by the contractor as indicated above. Report the full amount of funds recovered (i.e., monies actually refunded to the program as well as monies withheld as collection expenses by contractors or attorneys).

#### Example 1

A contractor who collected or identified TPL for \$900 retained 5 percent for his fee, and remitted \$855 to you. The recipient's medical expenses in relation to this insurance claim were in excess of \$900 and had been claimed by you for FFP. Report the \$900 collected from the third party resource on the HCFA Form 64.9a of the Quarterly Statement of Expenditures for the Medical Assistance Program. If your Federal medical assistance percentage (FMAP) is 60 percent, the Federal share is \$540. Report the contractor's fee of \$45 (.05 x 900) on HCFA Form 64.10 of the Quarterly Statement of Expenditures for reimbursement at the 50 percent allowable rate or \$22.50. The net recovery by HCFA after payment of FFP for the contingency fee is \$517.50.

Example 2

Assume the same facts as in Example 1, except that the State's FMAP rate is 50 percent. Report the \$900 recovered on the HCFA Form 64.9a; the Federal share is \$450. Report the contractor's fee of \$45 on HCFA Form 64.10 for reimbursement at the 50 percent allowable rate or \$22.50. The net recovery to HCFA after payment of FFP for the contingency fee is \$427.50.